The Psychodynamics of Hypertension

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• **Psychotherapeutic study of patients with essential hypertension shows evidence of massive repression of unacceptable feelings in many areas of the personality, predominantly feelings of rage and hostility. It appears that in the mentation of the hypertensive person, rage not only risks the loss of affection and approval by others, but is unconsciously equated by him with murderous loss of self-control. In addition, he characteristically has an inordinate fear of death.**

Intensive insight psychotherapy, when commenced early in a well-motivated patient, is very effective in the treatment of this disorder. As in any psychosomatic condition, the patient should be concomitantly treated by his general physician or by an internist.

WE ARE ALL familiar with the expressions, "Watch your blood pressure"; "Don't get your blood pressure up"; "Don't burst a blood vessel," applied to persons who are in the process of becoming angry or enraged; or again, "apoplectic with rage"; "flushed with anger"; "the veins stood out on his neck like cords." The import of all of these idiomatic expressions of folk knowledge is that rage, especially suppressed rage, has something to do with an increased blood pressure. And the composite of the psychic structure of the hypertensive patient, as obtained from psychotherapeutic scrutiny, amply seconds and supports this folk view.

The typical patient, with essential hypertension, as delineated by psychotherapeutic study, shows an external friendliness, blandiloquence and excellent self-control, beneath which there are powerful feelings of hostility, rage and anxiety. Latent repressed hostility is found in every neurosis, but the difference as noted in hypertension is that the emotions of rage are exceedingly intense, chronic, inhibited, repressed, not expressed in motility or adequately bound in any organized neurosis. The patients also are generally not able to satisfy passive dependent wishes or gratify hostile ones, and hence remain blocked in both directions. They have a "double bind" conflict here—they are "damned if they do, and damned if they don't."

Why does the person with hypertension have more of a problem in handling his rage than most of us? There is a variety of evidence suggesting that the repression of hostility is so massive because the patient's early experience of hostile rage, manifested either in thought or deed, became equated with murderous loss of self-control. From dreams and other sources we know that in unconscious mentation a thought is equated with the deed and is equally culpable with it. Hence the patient feels the same anxiety and guilt over fantasied acts of aggression as he might experience with completed ones. This basic unconscious pattern, which is learned very early, is transferred and perpetuated in all later competitive striving, such as in work, the achievement of social position, prestige, etc., so that success in these activities is also equated with murderous annihilation. Paradoxically, as success mounts, the individual has to work all the harder to keep rein on his hostile aggressive impulses and the guilt and terror attendant thereupon.

But important as the repression of hostility is in the genesis and progression of this illness, there is no convincing evidence that this factor is uniquely specific. Hypertension is known to be caused by fear, anger, sexual excitement, and sustained exertion and striving. If conscious, these states are appropriate and self-limiting, but if unconsciously repressed they are perpetual and enduring. Clinically, all these factors may be encountered in hypertension, singly and in combination, with repression of hostility the dominant though not the exclusive repression.

However, the early background of these patients casts a particular light on the genesis of these circular and mutual reinforcing neurotic mechanisms. In many such studies there has been found, as an outstanding feature of the antecedent environment, a profound sense of early insecurity in relation to primary familial figures. Death of a parent or separation from one occurred as a prevenient factor in over half of one such group.[1] In 23 of a group of 24 patients studied in the same group, serious hypertension was first observed after such emotional disturbance as severe illness of a relative, injury, illness or other trauma to the patient, changes in the patient's life, such as separation, divorce, illness of a child, loss of a job, or loss of savings—circumstances which recapitulated an earlier and unresolved traumatic conflict. In 13 of 24 the emotional disturb-

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ances seemed to be mainly a reaction to serious illness or death of a close relative.

In the author's experience these patients also characteristically show, both consciously and unconsciously, an inordinate fear of death; and from dream and other evidence it seems clear that they feel that their death must follow as a consequence of antecedent death wishes toward their ambivalently regarded love objects. The history of incipient essential hypertension is closely related and similar to that of early psychoneurosis: headache, dizziness, tinnitus, excessive fatigue, and mood changes are prominently described and are often out of proportion to the extent of physical disease that is present.

The role which intrapsychic factors play in the genesis of hypertension was further elucidated by Schulz and Schwab,[3] who found the incidence of hypertension in the American southern Negro to be two and one-half times that in whites. Kesilman,[2] in a survey conducted in a northern prison, found hypertension three times as common among Negroes as among whites; and since the African Negro is, of all peoples, the most free from this disease, it would appear that the singular pressures of life for the Negro in our culture have a relationship to this high incidence. The author has heard from a physician recently returned from Johannesburg that the clinics there in which urban Negroes are treated encounter a very high incidence of malignant hypertension, a disease unknown in the tribal populations.

The exact physiological mechanisms are not known whereby a persistent and unalleviated state of tension, stress and repressed rage produces the organic changes which may later become irreversible in hypertension. Wolf[4] and co-workers have reported evidence of renal vasoconstriction and ischemia in response to experimentally produced psychological stress: When conflictful and unpleasant matters were introduced into conversation with their subjects, the renal blood flow was reduced by as much as 25 per cent from the control level. It would be most interesting to know whether this process is intermittent or continuous in these patients and whether it causes the renal pressure phenomena which are now being so extensively studied.

As for psychotherapeutic measures, it is easy to see that if the rage and anxiety that are so conspicuously repressed are due to unconscious reasons, then counseling, support, reassurance, exhortation and advice to the patient to express his hostility more openly will be futile—and so it proves to be. No hypertensive patient was ever cured by being advised to beat his wife or talk back to the boss.

The consistent experience of the author and of other investigators is that intensive insight psychotherapy, if begun before irreversible organic change has taken place, with a motivated patient and by a psychiatrist adequately trained and experienced in this work, is almost always successful in alleviating or vastly modifying the illness. Since this process may involve anywhere from 50 to 350 hours of work, obviously no psychiatrist has a large series, but the general experience is that successfully treated patients remain normotensive, feel generally better and cope more successfully with a wide variety of life stresses, since the goal of successful psychotherapy is to resolve not only the presenting complaints but any concomitant neurotic difficulties.

It is important, however, that the patient be referred for psychotherapy early, before irreversible damage has occurred, and that the referring physician work conjointly with the psychiatrist in the medical management of the patient. This is the custom in psychiatry for two reasons: first, because the well-trained psychiatrist by the time his training is finished, is usually a decade away from his own intensive medical training and not generally competent to supply the quality of medical care which his colleagues can; second, because it is technically difficult to function at once as both psychotherapist and internist.

This whole area of the joint study and treatment of psychosomatic disorders such as hypertension has only begun to be explored. No greater opportunities exist for an expansion of the frontiers of medical understanding.

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